THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-4086.M5

MDR Tracking Number: M5-05-0823-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-8-04.

The IRO reviewed office visits, neuromuscular re-education, therapeutic exercises, therapeutic activities, and manual therapy from 12-3-03 through 2-6-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO determined that the office visits on 12-3-03, 12-31-03 and 1-23-04, and two units of therapeutic exercises and two units of therapeutic activities and one unit of manual therapy from 12-3-03 through 1-23-04 were medically necessary. The IRO agreed with the previous adverse determination that the office visits and all therapy services beyond 1-23-04 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO Decision.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 12-3-03 through 1-23-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 13th day of January 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

Specialty Independent Review Organization, Inc.

December 16, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-0823-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

Mr. ___ was injured on ___ while working for H&K Armored Service. He sustained injuries to the right shoulder and cervical spine. In a separate injury on ___, Mr. ___ also injured the lumbar spine. He has seen Dr. Seven Tjia, M.D. for pain management. Mr. ___ has seen Dr. J. Nathan Wilson, M.D. for surgical evaluation and ultimately an anterior diskectomy and fusion at C5/6 for this injury on ___ as well as a right shoulder rotator cuff repair and acromioplasty. He has also had a L3/4 fusion with decompressive laminectomy for the ___ injury on ___. Mr. ___ was placed at MMI with a 20% Impairment Rating. At some time, he changed treating doctors to Dr. Cotton D. Merritt, D.C. because Dr. Wilson was no longer continuing to treat worker's compensation patients.

By reviewing the records, Mr. ___ did not have any post-operative rehabilitation or physical therapy after the cervical diskectomy and fusion or the lumbar fusion. Upon being evaluated by Dr. Merritt, the recommendation was for active therapy to restore function to the cervical spine. Mr. ___ was referred for a Required Medical Examination by Texas Mutual Insurance with Dr. Gerald Hill, M.D. He was seen on 12/18/2003. Dr. Hill recommended a FCE that demonstrated significantly decreased function and light PDL, 40% decrease in ROM of the cervical spine and therefore was recommended only for sedentary work at most by Dr. Hill. Examination on11/20/2003 by Dr. Merritt recommends 8 weeks of rehabilitative therapy due to decreased functional abilities on examination.

DISPUTED SERVICES

Disputed services include office visits (99213, 99212-25), neuromuscular re-education (97112), therapeutic exercises (97110) therapeutic activities (97530) and manual therapy (97140) as denied by the carrier from 12/3/03 through 2/6/04.

DECISION

The reviewer disagrees with the previous adverse determination for Office visits 99213 on 12/03 and 99212-25 on 12/31/2003 and 1/23/2004. Therapy Services coded as 97110 for two units, 97530 for two units and 97140 for one unit would be considered reasonable and necessary.

The reviewer agrees with the previous adverse determination regarding the second unit of 97140 and 97112 services as they do are not medically reasonable and necessary according to the records. Office visits 99212-25 and all therapy services beyond 01/23/2004 would not be considered medically reasonable or necessary as well.

BASIS FOR THE DECISION

Mr. ___ would be entitled to a trial of care for at minimum of two weeks to determine if therapy would be beneficial in improving his condition. Due to the chronicity of this condition as the surgery was approximately one year prior to starting therapy, this timeframe may be extended. Re-evaluations are necessary to document progress for necessity of further care, but it is not reasonable to perform them more frequently than two weeks or 6 visit intervals.

By 01/23/2004, Mr. ___ had 12 visits of active care and did not have a significant improvement in his condition and had seemingly plateaued. Therefore, the reasonableness of care is not substantiated beyond that time. Guidelines suggest a 25 percent improvement in condition to indicate further care is necessary. Objective measurements do not substantiate this level of improvement from examination on 11/20/2003 through 1/23/2004.

It does appear that two times per week may have been a case of underutilization where one would expect three times per week to encourage functional gains. Additionally, there were gaps in care through the holiday season that may have prevented Mr. ___ from achieving or maintaining functional gains.

The reviewer cannot support the therapy code of neuromuscular re-education at any time (97112) as the records reflect this is for treatment of the lower back and this is not compensable for this injury date. The additional unit of myofascial release does not appear justified by the records as one would expect the joint mobilization to be a component of the synergy exercises as it is not specifically documented what mobilization was occurring. Furthermore, the manual therapies are not documented or detailed. The 97110 services and 97530 services are part of a normal conditioning program and contain exercises as expected to achieve functional gains.

Guidelines supportive of this recommendation are the Council of Chiropractic Physiological Therapeutics & Rehabilitation Guidelines, Mercy Conference Guidelines and Rand Consensus Panel. Therapy recommendations are derived utilizing Rehabilitation for the Postsurgical Orthopedic Patient, Maxey and Magnusson, Mosby, 2001.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director